NHS
North West
Ambulance Service
NHS Trust

Urgent and Emergency Care Strategy

2019-2024

Delivering the right care, at the right time, in the right place; every time

Recommended by	Executive Management Team
Approved by	Board of Directors
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Responsible Manager (Sponsor)	Assistant Director Transformation
For use by	All Staff, Commissioners, Stakeholders

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EXECUTIVE SUMMARY

We have stated our ambition to be the best ambulance service in the UK; delivering the right care, at the right time, in the right place; every time. This ambition is built on the understanding that delivering patient care at the right time in the right place is reliant on the delivery of an integrated urgent and emergency care model.

We have also stated our ambition to be in the top three performing ambulance trusts by 2021, and to be the best ambulance service in the UK by 2023. This Urgent and Emergency Care (Right time, Right place) Strategy describes how we will deliver effective urgent and emergency care (UEC) for every patient by adopting a system wide integrated response model. The strategy also recognises the importance of delivering outstanding patient outcomes and should be viewed in conjunction with our new Quality Strategy (Right Care - approved October 2018).

Our primary objective is always to ensure that patients presenting with serious or life-threatening emergencies receive timely high quality care in order to maximise their chances of survival and recovery. We aim to achieve ambulance response standards consistently and sustainably by working in collaboration with the wider healthcare system to develop a range of integrated urgent and emergency care solutions. This will ensure that emergency resources are able to provide a timely response; every time.

While we maintain our position as the core provider of pre-hospital emergency care in the North West, we will also position NWAS firmly at the centre of a whole system integrated urgent care (IUC) model. We recognise that we are ideally placed to provide high quality patient-centred care closer to home, in order to treat more patients, by telephone, at scene, and in community settings; thereby reducing unnecessary conveyance to hospital.

In recent years, our ability to provide a timely response to emergency patients has often been challenged by growing demand from patients with urgent care needs, delays caused by increased hospital handover times, and system reconfigurations, all of which need to be delivered within a nationally-recognised restricted financial envelope.

In considering these challenges and the context in which NWAS operates, our response is to implement a fully integrated urgent and emergency care model which will enable us to achieve the following core aims of this strategy:

1. For those people with urgent but non-life-threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible minimising disruption and inconvenience for patients and their families.

2. For those people with more serious or life-threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

We will achieve our aims through a focus on the following three strategic priorities which are underpinned by key objectives:

STRATEGIC PRIORITIES	OBJECTIVES
1. Emergency care	We are committed to delivering the requirements of the National Ambulance Commissioning Framework and the 999 service specification throughout the term of this strategy. We are committed to sustainably achieving and maintaining all ambulance response standards and become the best performing ambulance trust by 2023. We will complete a full roster review and implementation by the end of 2019/20. We will review and reconfigure our existing EOC and contact centre functions within the first two years of this strategy to ensure that we provide an efficient, appropriately resourced and resilient service at all times. We are committed to sustainably achieving all national response standards for healthcare professional (HCP) and interfacility transfer (IFT) requests within the term of this strategy, in order to provide a fair and equitable response to all patients, every time.
2. Integrated urgent care (IUC)	We will commit to a fully integrated clinical assessment service (CAS) that will complement our resource dispatch functions. We will engage with commissioners, Sustainability and Transformation Partnerships (STPs) and providers to ensure that we are a key partner in delivering IUC solutions which align to population demography and healthcare needs, including prevention. We will proactively engage with, and develop provider partnerships in order to implement an effective IUC model of care.
3. Service delivery model	Within the first year of this strategy we will restructure service delivery functions in way that delivers an effective balance between clinical and operational leadership for populations aligned with the STP footprints. Within the first year of this strategy we will undertake a review of UEC structures that will enable rapid and scalable delivery of IUC.

This strategy will be supported by a full implementation plan, which will be developed to include a summary of objectives, deliverables, timescales, benefits and measures to go alongside the five-stage patient journey model.

The integrated response model approach will ensure that we functionally integrate our 999, 111, and PTS businesses, whilst harnessing capacity across the whole economy for the purposes of seamless patient care, in which needless waiting is eliminated.

In short, we are committing to a significant organisational change process which will position NWAS as the lead provider for both emergency and urgent care.

1. INTRODUCTION

Background

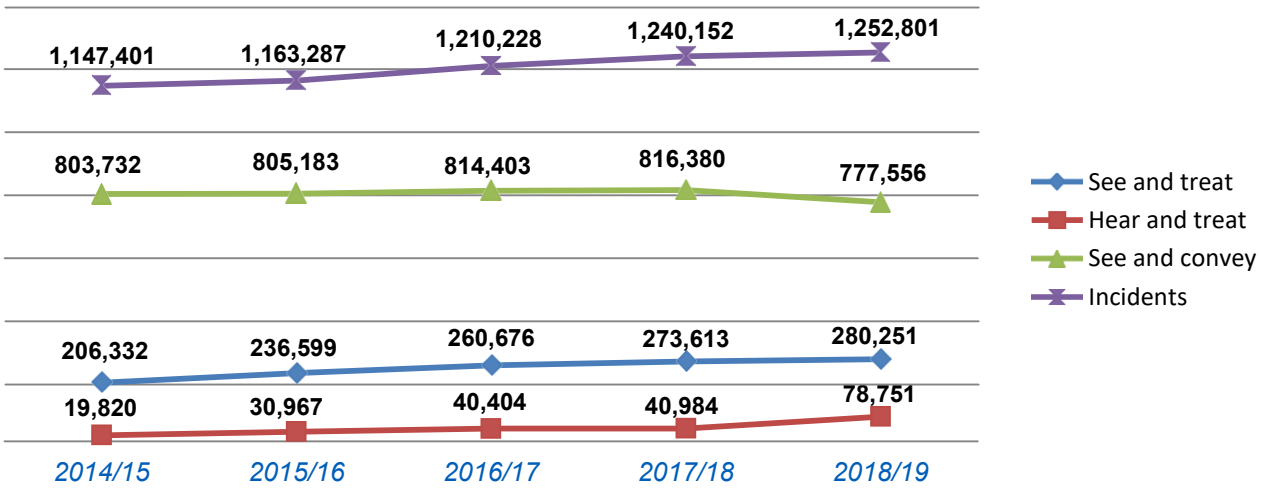
Across England and the UK, the ambulance sector has experienced increases in activity, year on year, with little indication of a slowdown in the rate of growth. Funding for those services has not kept pace with rising demand and continued financial pressure is likely. In 2017/18, we received more than 1.3m 999 calls and provided a response to more than 1.1m incidents. In addition, we managed over 1.7m calls through the NHS 111 service, and over 2m Patient Transport contacts. In the same year we also lost over 70,000 ambulance hours due to delays in ambulance turnaround at hospitals.

In response to these ongoing challenges, we embarked on a two-year transformation programme known as 'Transforming Patient Care'. The programme was designed to ensure that patients could be managed without transportation to emergency departments (EDs) whenever clinically appropriate; increasing the number of patients managed by telephone advice, see and treat, or by using pathways of care other than ED attendance.

The transformation programme adopted the principles outlined within our five-stage patient journey model (also known as left shift). Tested through Transforming Patient Care, the core aim of the model was to reduce needless waiting and to provide clinical advice and intervention at the earliest opportunity within the patient journey.

During year one of the programme, despite incident growth, we saw a small numerical reduction in conveyance to hospital for the first time since the creation of the trust in 2006. During 2018/19 we estimate that we will convey 40,000 fewer patients than in the previous year, despite similar levels of growth.

Table 1 *Shift in activity flow 2014/15-2017/18 (Impact of Transforming Patient Care)*



The programme has also established the principles of early clinical intervention (left shift) as a crucial enabler for patients with life-threatening needs to receive a timely response and potentially improved prognosis. Put simply, more effective management of patients with mid to low acuity needs, maximises our ability to respond to higher acuity patients, thus improving our performance against Ambulance Response Programme (ARP) standards. Indeed, the five-stage patient journey model has been adopted by the Ambulance Improvement Programme Board and NHS Digital as the approved framework for care delivery.

We now intend to build on the foundations of the Transforming Patient Care programme and continue to provide a service for urgent and emergency care that is sustainable and resilient, with equity of access for the whole population.

Throughout the delivery and implementation of the principles of the strategy, we will, at all times, strive to release emergency resources to deliver the best care for patients with the most serious or life-threatening conditions. We remain committed to delivering our responsibilities as a category **1** responder, our legislative responsibilities relating to emergency preparedness, resilience, and response (EPRR), and to ensure that non-conveyance decisions are clinically appropriate at all times.

What is urgent and emergency care?

Urgent care involves a range of services that are available for the public to access where there is an urgent actual or perceived need for intervention by a health or social care professional. In practice this will mean that people, whatever their urgent care need, wherever the location, get the right care, from the right person, in the right place, at the right time; every time.

Emergency care is an immediate response to a time critical health need. A small number of people suffer from serious illness or have a major injury which requires rapid access to highly skilled, specialist care to give them the best chance of survival and recovery.

We believe that outstanding provision of urgent and emergency care will be defined as:

Patient focused

Based on good clinical outcomes

Timely

Right the first time

Available 24/7 to the same standard wherever possible

About us

North West Ambulance Service NHS Trust (NWAS) was established on 1 July 2006, following the merger of ambulance trusts from Greater Manchester, Cheshire and Merseyside, Cumbria and Lancashire. We have a workforce of over 6,000 people, operating its services from 109 ambulance stations distributed across the region, three emergency operations centres, one support centre, and two Hazardous Area Rescue Team (HART) centres.

In addition, the trust also provides, along with urgent care and out of hours (OOH) partners, the NHS 111 service for the North West region, operating from sites in Greater Manchester, Merseyside, Lancashire and Cumbria. Our operational area covers a population of approximately 7.5 million people over five counties. We respond to patients across a geographical footprint of approximately 5,400 square miles. These populations are served by four Sustainability and Transformation Partnerships (STPs)/ integrated care systems (ICSs) in Greater Manchester, Cumbria, Lancashire and Cheshire and Mersey.

We are one of the largest ambulance services in the UK receiving over 1.3 million emergency calls per year, with telephone-based clinicians and emergency crews attending to more than 1.2 million incidents each year (2017/18).

Demand for our services continues to grow every year, but despite this, we are committed to providing an outstanding level of patient care for every patient, every time.

Our NHS 111 service is the largest in the UK taking over 1.7 million calls each year. We undertake more than 1.2 million non-emergency patient transport journeys each year through our Patient Transport Service (PTS). In total we manage more than 3.5 million patient contacts every year. We also forms part of the NHS response to major incidents, ensuring that plans are in place to provide a comprehensive response to major incidents, risks, or hazards.

National strategy and policy drivers

NHS England's Five Year Forward View (5YFV) was the pivotal document in outlining requirements for change, specifically relating to demand management, operational efficiencies, and funding. Within the 5YFV there are specific policy recommendations that call for redesign of urgent and emergency care services to enable integration between A&E departments, GP OOHs, urgent care centres, NHS 111, and ambulance services.

The 5YFV also called for ambulance services to provide an enhanced clinical decision making role with paramedics supporting the delivery of safe care closer to home and within community services. It goes further to call for a strengthened clinical triage and advice service that links the system together and helps patients navigate more successfully.

These principles are reflected in the Urgent and Emergency Care Review (UECR), Commissioning Standards for Integrated Urgent Care (Sept 2015), Clinical Models for Ambulance Services (Nov 2015), and more recently Guidance on the Implementation of a Clinical Hub (July 2016).

Transforming Urgent & Emergency Care Services in England (Safer, Faster, Better) endorses that "ambulance services play a central role in the provision of urgent and emergency care"; "ambulance services and their commissioners should work together to develop a mobile urgent treatment service capable of dealing with more people at scene and avoiding unnecessary journeys to hospital." This document can be accessed at: **https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf**

In particular, the UECR (update 2015) enforces the need to address gaps in health and wellbeing, care and quality, funding and efficiency, and sets two primary objectives for ambulance trusts:

1. For those people with urgent but non-life-threatening needs we must provide highly responsive effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible minimising disruption and inconvenience for patients and their families.

2. For those people with more serious of life-threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

We are committed to delivering the objectives of the UECR, and as such, are adopting these objectives as the core aims of our UEC Strategy.

The national policy context also offers us a unique opportunity to position the organisation as the primary provider of urgent and emergency care provision in the North West. We are the existing provider of 999, NHS 111, and PTS services and will always seek to ensure patients are managed in adherence with the principles of the UECR.

Lord Carter review

The recent publication of Lord Carter's review highlights a number of key areas of required improvement in operational delivery. These are:

1. Staff
2. Digital
3. Fleet

This strategy recognises the need for our workforce to be more flexible, receive enhanced managerial and clinical support, and be rostered effectively to meet the profile of activity demand more effectively. Lord Carter's report also stressed the importance of addressing challenges to productivity such as hospital handover delays, a reduction in conveyance to emergency departments, and the use of alternative pathways of care such as urgent treatment centres.

It is not the intention of this strategy to provide detailed overviews of support service strategies such as fleet, workforce, finance, and others, but in determining our direction of travel for the delivery of core UEC services, organisational strategies must be aligned to the core principles of right care, right time, right place; every time. We will set clear aspiration targets for the achievement of reducing emergency department conveyance by managing patients before the call, or by hear and treat or see and treat methods whenever clinically appropriate.

The NHS Long Term Plan (LTP)

Pre-hospital urgent care is a vital component of the NHS LTP. Sections 1.27 states:

> 1.27. Ambulance services are at the heart of the urgent and emergency care system. We will work with commissioners to put in place timely l"e spon ses so patients can be t reated by skilled paramedics at home or in a more appropriate setting outside of hospital. We will implement the recommendations from Lord Carter's recent report on operational produ ctivity and performance in ambulance trusts. ensuring that ambulanı **servkes** are able to offer the most clinically and O!Jerationally effective res!]onse. We will m ntinue to work with ambulance services to eliminate hospital handover delays. We will also increase sp ecialist ambulance capability to respond to terrorism. Capital investment will continue to be targeted at fleet upgrades, and NHS England will set out a new national framework to overcome the fragmentation that ambulance services have experienced in how they are locally commissioned.

Building on the work started by the SYFV, the LTP highlights a number of key areas of strategic change relating to the reduction of pressure on emergency hospital services. There is clear intent to support patients to navigate the optimal service 'channel'. The LTP commits to embedding a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP OOH services from 2019/20.

> 1.25 . **To support patients to navigate the optimal service 'channel', we will embed a single multidisciplinary Clinical Assessment Service (CAS} within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20 .** This will provide specialist advice, treatment and referral from a wide array of healthcare professionals, encompassing both physical and mental health supported by collaboration plans with all secondary care providers . Access to medical records will enable better care. The CAS will also support health professionals working outside hospital settings, staff within care homes, paramedics at the scene of an incident and other community-based clinicians to make the best possible decision about how to support patients closer to home and potentially avoid unnecessary trips to A&E. This includes using the CAS to simplify the process for GPs, ambulance services, community teams and social care to make referrals via a single point of access for an urgent response from community health services using the new model described

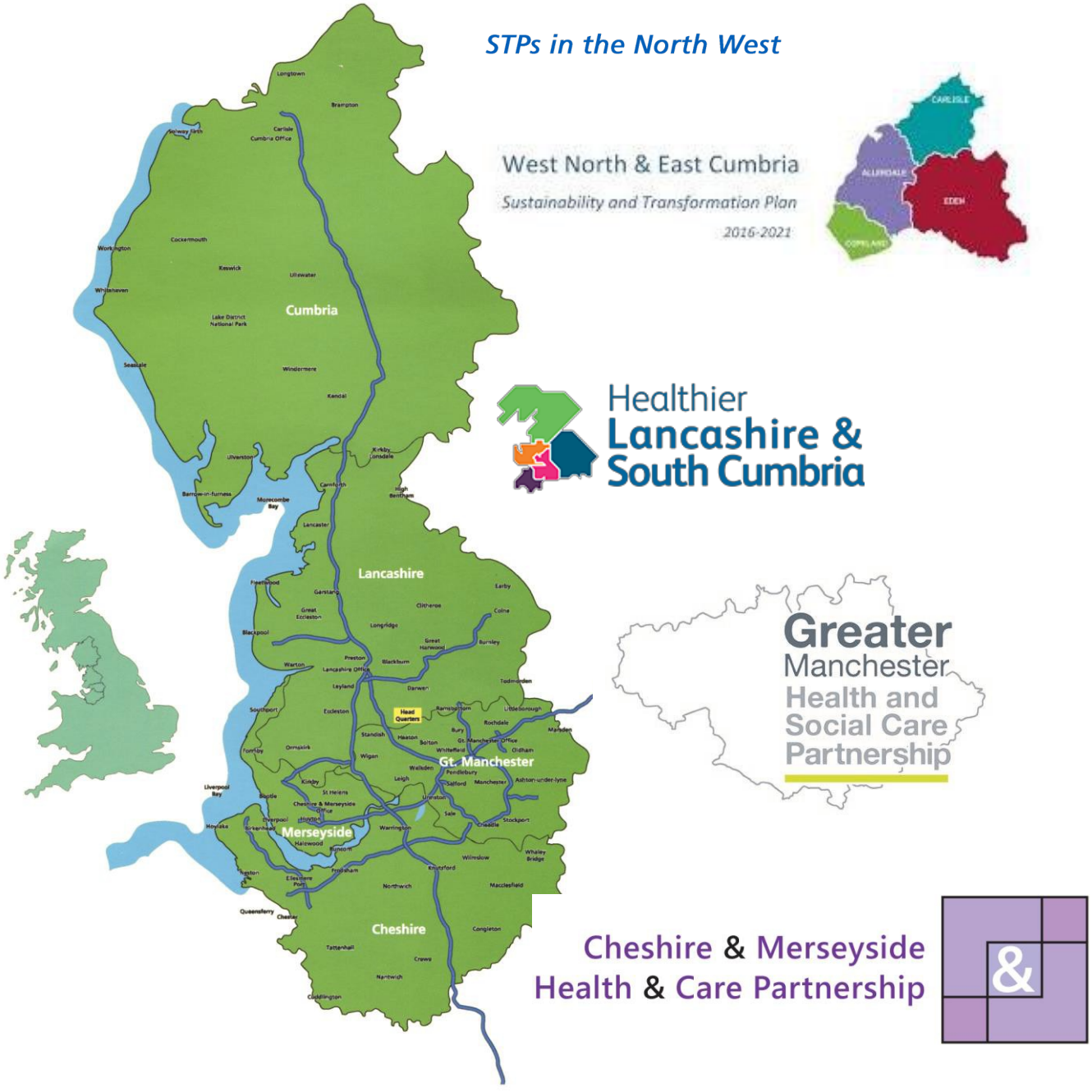
This vision of an effective integrated urgent care model will also be designed to support a wide range of healthcare professionals to manage patients closer to home, including a paramedic at the scene of an incident. We have been at the forefront of CAS development since 2015, developing the concept of integrated virtual clinical hubs (IVCH) in partnership with other primary and urgent care providers.

This response model has developed into a rationalised clinical hub function together with acute primary assessment services (APAS) which have started to manage some NHS 111 incidents and low acuity 999 Category 3 and Category 4 activity. The result has been a demonstrable increase in hear and treat outcomes and reduced conveyance, thereby maintaining our ability to deliver sustainable performance improvements without receiving investment in critical levels of resources, as determined by external modelling consultants. It is crucial that we utilise our considerable expertise in this area in order to provide support to emerging models of care.

Regional drivers

The NHS and local councils in England have formed partnerships to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations.

STPs will build upon collaborative work to support implementation of an integrated response model, which outlines a number of areas in which changes to urgent and emergency care are needed. Key themes include: shifts towards more lower acuity urgent care settings such as urgent treatment centres or GP practices, improved access to primary care, support for older adults to stay healthy and at home with improved prevention and integrated care.



The implementation of NHS 111 services means that we are now the 'gateway' for over 3 million unscheduled care contacts each year. The need to provide enhanced triage through effective, clinically focused, decision making in our contact centres is crucial in the context of fulfilling the requirements of the national policies and local commissioning intentions.

Every year, we visit the homes of approximately 2 million patients requiring planned hospital transport. These are often the more frail and vulnerable patients within the North West. This provides a superb opportunity for prevention and health promotion opportunities to improve care and manage demand.

Foremost amongst the causes of urgent and emergency care system pressure is the ageing population. By 2030 the North West will be classified as having a super-ageing population, with more than 20% of the population aged over 65 years. National targets for managing patients away from traditional emergency departments do not always consider the specific population health challenges of the North West such as frailty, cardiovascular disease, respiratory disease, obesity, and mental health.

Reconfiguration and transformation schemes such as Devolution Manchester, Cumbria Success Regime, Healthier Liverpool, and others, further emphasise the need that a 'one size fits all' service is not sustainable, rather we must focus on delivering a service that can be both regionally and locally implemented depending on the needs of individual areas.

2. WHAT ARE WE TRYING TO ACHIEVE?

We have stated our ambition to be the best ambulance service in the UK; delivering the right care, at the right time, in the right place; every time. This ambition is built on the understanding that delivering patient care at the right time in the right place is reliant on the delivery of an integrated urgent and emergency care model.

Our primary objective is always to ensure that patients with serious or life-threatening emergency needs receive timely high quality care in order to maximise their chances of survival and recovery. We aim to achieve ambulance response standards consistently and sustainably by working in collaboration with the wider healthcare system to develop a range of integrated urgent and emergency care solutions. This will ensure that emergency resources are able to provide a timely response; every time.

While we maintain our position as the core provider of pre-hospital emergency care in the North West, we will also position the organisation firmly at the centre of a whole system integrated urgent care (IUC) model. We recognise that we are ideally placed to provide high quality patient-centred care closer to home, in order to treat more patients, by telephone, at scene, and in community settings; thereby reducing unnecessary conveyance to hospital.

What are our challenges?

In recent years, our ability to provide a timely response to emergency patients has often been challenged by growing demand from patients with urgent care needs, delays caused by increased hospital handover times, and system reconfigurations, all of which need to be delivered within a nationally-recognised restricted financial envelope. These challenges are further exacerbated by the need to improve our digital solutions.

Operational delivery and performance/national standards

We recognise that our approach to delivery of UEC services must adapt if we are to meet the national ambulance response standards on a sustainable basis. We have an evolving operational model but acknowledge that we have not always been as effective as we would like in our response to changes in UEC. The need to deliver sustainable ambulance response standards has often limited our capacity to achieve large-scale organisational change.

While we can demonstrate our ability to be innovative, and significant improvements have been made, we recognise that we must translate this innovation and improvement into sustainably delivered quality, performance, and service standards.

Demand growth

Using incident activity* as a measure of activity growth, 999 activity has risen by 28% from a 2011/12 out-turn of 968,720 incidents to 1,240,152 incidents in 2017/18. It must be acknowledged that operational budgets have not kept pace with activity growth and therefore alternative methods of delivering care have been employed to allow us to maintain operational capability.

**Patient incidents requiring a telephone or face-to-face response.*

Total incidents (hear and treat+ see and treat+ see and convey)							
Year	2011/12	2012/13	2013/14	2014/15**	2015/16	2016/17	2017/18
Incidents	968,720	1,000,187	1,001,594	1,041,040	1,163,287	1,210,228	1,240,152
Annual Growth		31,467	1,407	39,446	122,247	46,941	29,924
Percentage Growth		3.25%	0.14%	3.94%	11.74%	4.04%	2.47%

** *Includes 111-999 activity from 2014/15*

As well as incident growth, the five year call demand trend of c. 5.6% has been above the all-England average of 5.2%. We expect to see a further 38% in call growth over the next ten years (Carter 2018) and must therefore adapt our working practices to manage these exceptional levels of activity within restrictive financial budgets. In doing so, and to manage demand across all categories of urgent and emergency care, including healthcare professional activity, we must develop integrated working practices that bring together providers from the wider health system as the lead provider and primary coordinator.

While activity growth from 2003 onwards has predominantly been concentrated in patients with urgent care needs, over the last few years we have also seen a significant rise in patients presenting with high acuity conditions, and increased journey times associated with service reconfigurations. While much of the growth has been mitigated by using community services, those patients being conveyed to emergency departments are at a much higher risk of admission to hospital. This places pressure on emergency departments whose 'major' patients often need more complex investigations and interventions.

We are committed to working with the wider system to harness capacity within community based services for patient groups who can be cared for in more effective ways. We intend to work hard on improving the quality of care for all patients, but will be focusing on several patient groups for whom bespoke pathways of care can be beneficial to the clinical outcomes and patient experience.

These include:

- Mental health and dementia
- Older people and frailty
- Patients experiencing falls
- Paediatrics
- Cardiovascular disease (CVD)

Hospital handover

In England, more than 500,000 hours of time critical ambulance response capacity was lost in 2017/18 due to delays in handing over patients to emergency departments. In the North West alone, we lost more than 70,000 hours of resource time during the year. The impact on our ability to respond to seriously ill or injured patients seriously compromises the quality of care that we aim to provide.

There are a number of significant factors that impact on handover times, such as blockages with the hospital system itself, delays in emergency departments, inappropriate conveyance to hospital, and timely access into community services.

During 2018/19 we have worked extensively to address the resource loss through excessive hospital turnaround times. While we have seen some improvements in trusts with historical turnaround challenges, improvements across the whole acute trust sector have not been sustainably delivered.

Digital

We are aware that our digital capabilities require improvement. 999, NHS 111, and PTS services operate on disparate systems that do not currently allow us to harness the potential utility of our workforce, estates, and business intelligence in the most efficient way. Whilst we have taken steps to introduce an Electronic Patient Record (ePR) the process has been slower than we anticipated. Integrated software is in need of further development, and our ability to access and shared patient information has been compromised as a result. The need for urgent and emergency care services to be supported by our new digital strategy has never been more apparent.

Finances

Our ability to provide a sustainable, efficient service will be reliant upon receipt of sufficient funding. In the future the contract framework will need to be more flexible and sophisticated to support the delivery of integrated service models.

Population

We believe that understanding the needs of our population is crucial in delivering effective urgent and emergency care. Our service traverses a diverse geographical footprint, with an ever increasing complexity within the patient demography. Male and female life expectancy are both below the all England average, there are high levels of social deprivation, with a significant number of local authority areas falling within the most deprived 10-20% in England. Nine of the top 20 most deprived local authority areas are in the North West. (NAO 2015 Index of Multiple Deprivations)

We have consistently been under enormous pressure to convey fewer patients to emergency departments across the North West. While significant progress has been made, especially in management of low acuity patients by telephone advice, the number of patients managed on scene is lower than the all-England average.

The patient demographic of the North West is one of the biggest single challenges in maximising opportunities for pre-hospital management. High levels of social deprivation, especially in the Greater Manchester and Mersey conurbations, as well as specific condition presentations, create an environment in which health inequality with

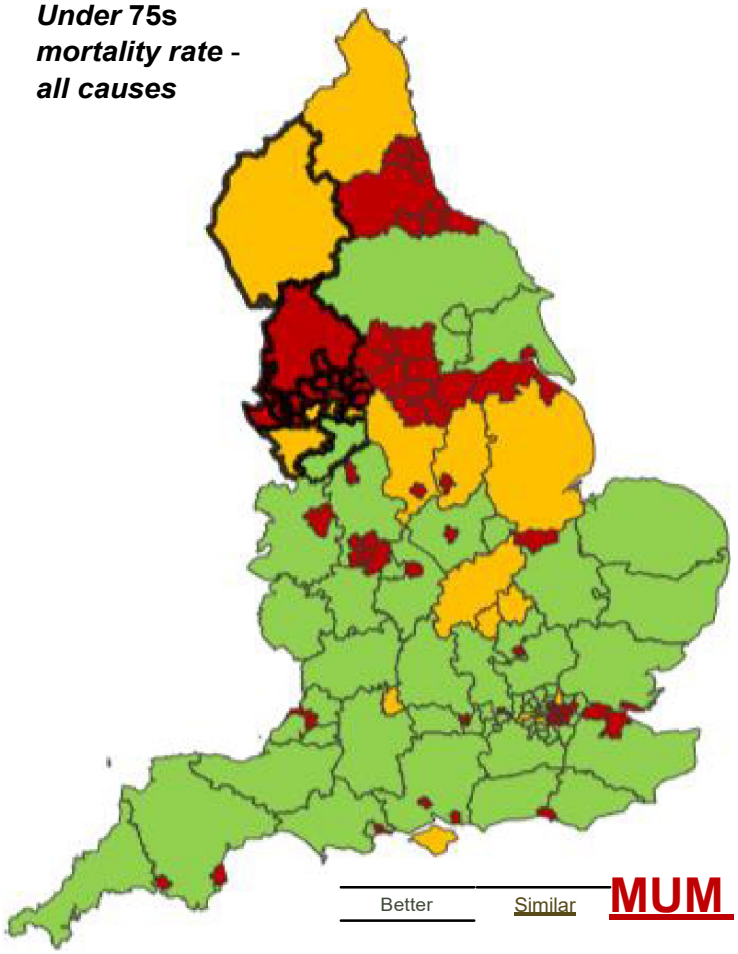
the rest of the UK is widening. While people in the more affluent local authority areas experience better than average health, the reverse is true in the areas with the highest levels of deprivation, where health is generally worse than the England average.

Neighbourhood poverty is linked to poor long-term physical and mental health, as well as an increased prevalence of cardiovascular risk factors such as obesity and diabetes. Indeed, in the North West there is a 1.6-1.8 times likelihood of childhood obesity than the national average, and levels of alcohol and smoking related illness continue to be higher than in most areas of the UK. Despite improvements in population risk factors in recent years and reductions in mortality from coronary heart disease (CHD) socioeconomic gradients in health status have persisted or worsened. In the context of the extremely tight fiscal climate, these inequalities are expected to worsen further.

We are expecting high levels of incident growth over the next ten years. Evidence suggests that growth will also come with increasing levels of complex medical conditions in a super-ageing population. The baseline characteristics of neighbourhood poverty also strongly suggest higher levels of hypertension, smoking, diabetes, obesity, high cholesterol, statin use, and mental health related conditions.

The North West has a diverse population, wide variation in distribution of wealth, and while life is not 'grim up north' the stark truth is that on average because of poorer health, people in the North West suffer shorter lifetimes and suffer more years of ill-heath than in the South.

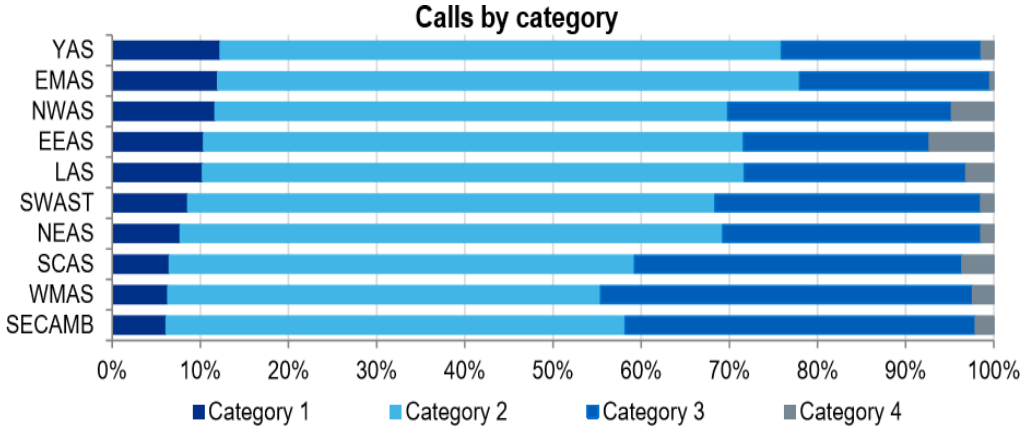
Under 75s mortality rate - all causes



In the North West, premature mortality outcomes for the biggest causes of early death (under the age of 75) are among the worst in the UK. The impact on the ambulance service is significant with a proportionately higher number of patients presenting with cardiovascular and respiratory presentations than those in the south of the country.

While we enjoy a hugely diverse population, this diversity tends to be concentrated in urban, and often deprived areas. There are health inequalities and high instances of certain types of conditions in different diverse groups which can have a significant effect on our models of care. In our region, 18% of men and 31% of women, who are of working age, are not in employment. This is above the national average.

The proportion of high acuity Category 1 calls among English ambulance services reflects the levels of deprivation, premature death rates, and complex co-morbidities highlighted by the National Audit Office figures.



System engagement

We are jointly commissioned by 31 Clinical Commissioning Groups (CCGs) to provide urgent and emergency care services across the north west of England. There are four STPs with the role of bringing together local health and care leaders to deliver system-wide transformation which meet the needs of local communities.

We therefore operate across a highly complex geographical location with growing expectations to meet the urgent and emergency care needs of its population through greater integration and collaboration with health and care partners across the North West.

Integration with local health and social care systems necessitates a review of the internal managerial and clinical leadership structures within NWAS. This strategy will make clear recommendations and commitments towards a restructured operational model that will enable us to provide highly effective clinically led services over the next five years and beyond.

Our response

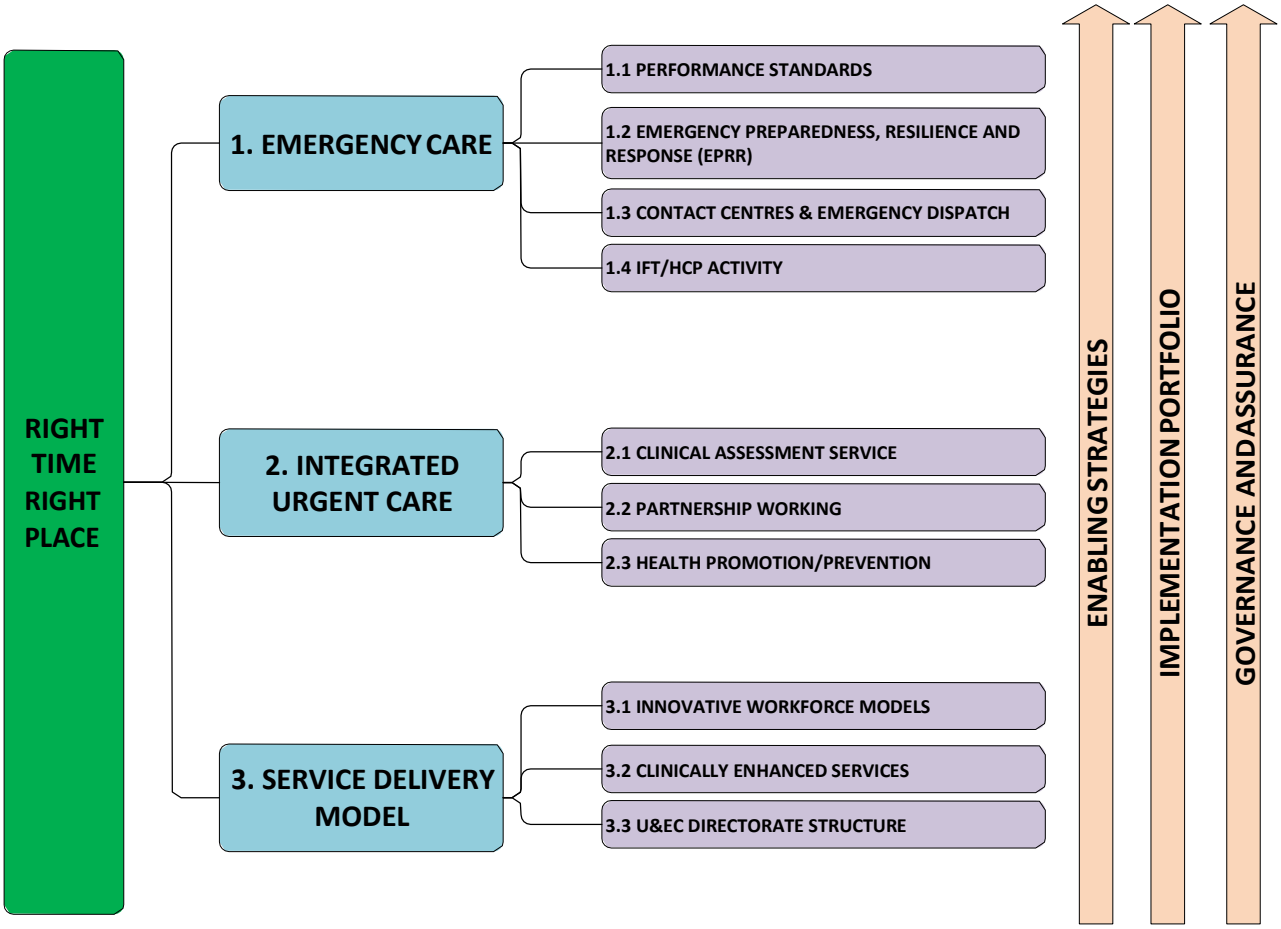
In considering these challenges and the context in which we operate, our response is to implement a fully integrated urgent and emergency care model which will enable us to achieve the following core aims of this strategy:

1. For those people with urgent but non-life threatening needs we must provide highly responsive effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible minimising disruption and inconvenience for patients and their families.

2. For those people with more serious or life-threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

3. HOW WILL WE ACHIEVE OUR AIMS?

The following driver diagram illustrates our approach to achieving the aims of this strategy:



We have identified three strategic priorities:

- **Emergency care**
- **Integrated urgent care**
- **Service delivery model**

These are further explained within the remaining sections of this strategy including the underpinning objectives for each.

Priority 1: Emergency care

1.1 Performance standards

Ambulance Response Programme {ARP)

The development of a combined UEC Strategy recognises our commitment to the principles of national, regional, and local drivers, but also that we must continue to provide a highly responsive and sustainable emergency response to those patients requiring immediate assessment and treatment. The document describes our commitment to delivering full ARP standards and how we will ensure that resources are used effectively through efficient use of emergency dispatch functions and control.

We have statutory obligations to deliver emergency responses in full compliance with ARP. Following the largest clinical ambulance trials in the world, NHS England announced a new set of measures for ambulance services. The changes focus on making sure the best, high quality, most appropriate response is provided for each patient first time. This includes providing call handlers with more time to assess 999 calls that are not immediately life-threatening, enabling them to identify patients' needs more efficiently, and identify the most appropriate response.

Categories of call are as follows:

Category	Response	Average response time
Category 1	For calls to people with immediately life-threatening and time critical injuries and illnesses.	These will be responded to in a mean average time of **seven minutes** and at least 9 out of 10 times before **15 minutes.**
Category 2	For emergency calls. Stroke patients will fall into this category and will get to hospital or a specialist stroke unit quicker because we can send the most appropriate vehicle first time.	These will be responded to in a mean average time of **18 minutes** and at least 9 out of 10 times before **40 minutes.**
Category 3	For urgent calls. In some instances, patients in this category may be treated by ambulance staff in their own home. These types of calls will be responded to at least 9 out of 10 times before 120 minutes	These types of calls will be responded to at least 9 out of 10 times before **120 minutes.**
Category4	For less urgent calls. In some instances, patients may be given advice over the telephone or referred to another service such as a GP or pharmacist.	These less urgent calls will be responded to at least 9 out of 10 times before 180 minutes

Under ARP, early recognition of life-threatening conditions, particularly cardiac arrest, increased. A new set of pre-triage questions identifies those patients in need of the fastest response. New targets were also designed to free up more vehicles and staff to respond to emergencies. We implemented these changes in August 2017, although we recognise that we have much work to do to ensure that our service delivery models harness the potential benefits of ARP.

Partnership working will be essential to improve care for our patients. In the years ahead we will support STPs to realise their vision for healthcare improvements. We know that the STPs have differing needs and priorities and we will ensure we support them to deliver their individual aims.

Managing demand is a complex process. It relies on changing attitudes amongst the public and changing system wide processes or customs that have long been established. We have a key role to play in working proactively with STPs to support the delivery of an integrated response model, and associated demand management initiatives.

The revised standards can be accessed at:

www.england.nhs.uk/statisticslstatistical-work-areas/ambulance-quality-indicators

Delivery of emergency operations (statutory and contractual requirements}

We are contracted under the NHS Standard Contract which is the mandated form of contract for ambulance services. This can be accessed at https://www.england.nhs.uk/nhs-standard-contract/.

Within the National Ambulance Commissioning Framework for commissioning of ambulance services, the new National Urgent and Emergency Ambulance Service 999 Specification incorporates the core elements for delivery of urgent and emergency ambulance services.

Workforce rostering

Provision of a high-performing, safe and effective 999 services can be mapped to the domains within the NHS Outcomes Framework. We have recognised that current roster patterns do not always reflect current or emerging demand patterns. While we committed to a robust Performance Improvement Plan (PIP) during 2018/19, a full review of our roster patterns is required across all operational areas of the trust (including Emergency Control, NHS 111, and Contact Centres). During the first twelve months of this strategy we will work with external consultants to ensure that our rosters are profiled against demand and that staff and resources are efficiently managed. Further, continuous review of working patterns will ensure that staff and vehicle resources are optimised at all times and that there remains a dialogue with staff over effective working patterns to support work life balance and retention of staff.

Effective rostering will be supported by the separate digital strategy which will review all digital and interoperability solutions across service delivery and support services such as human resources, central recruitment, fleet, finance and procurement. It is imperative that rosters recognise the newly configured fleet profile, maximising the use of emergency ambulances to improve efficiency and reduce responses per incident.

Objectives:

We are committed to delivering the requirements of the National Ambulance Commissioning Framework and the 999 Service Specification throughout the term of this strategy.

We are committed to sustainably achieving and maintaining all ambulance response standards and become the best performing ambulance trust by 2023.

We will a complete a full roster review and implementation by the end of 2019/20.

1.2 Emergency preparedness, resilience and response (EPRR)

All ambulance services hold a number of responsibilities in respect of EPRR. The requirements for ambulance services are also listed within the NHS England EPRR Framework **https://www.england.nhs.uk/ourwork/eprr/gf/**

We will continue to provide services, planning and service capability to deliver our obligations as a Category 1 Responder as laid down in the Civil Contingencies Act 2004 and in line with the requirements of the Department of Health's Emergency Planning Guidance (2005).

We will work cooperatively with the other emergency services and other Category 1 and 2 responders, including but not limited to participating in the planning and exercise testing processes, and will continue to work cooperatively with the Home Office National Interoperability programme.

Full statutory responsibilities for ambulance services are detailed within the Civil Contingencies Act (2004) and are available via the following links:

https:llwww. gov.uklgovernmentlpublicationslemergency-preparedness
https:llwww. gov.uklgovernmentlpublicationslemergency-response-and-recovery

1.3 Contact centres and emergency dispatch

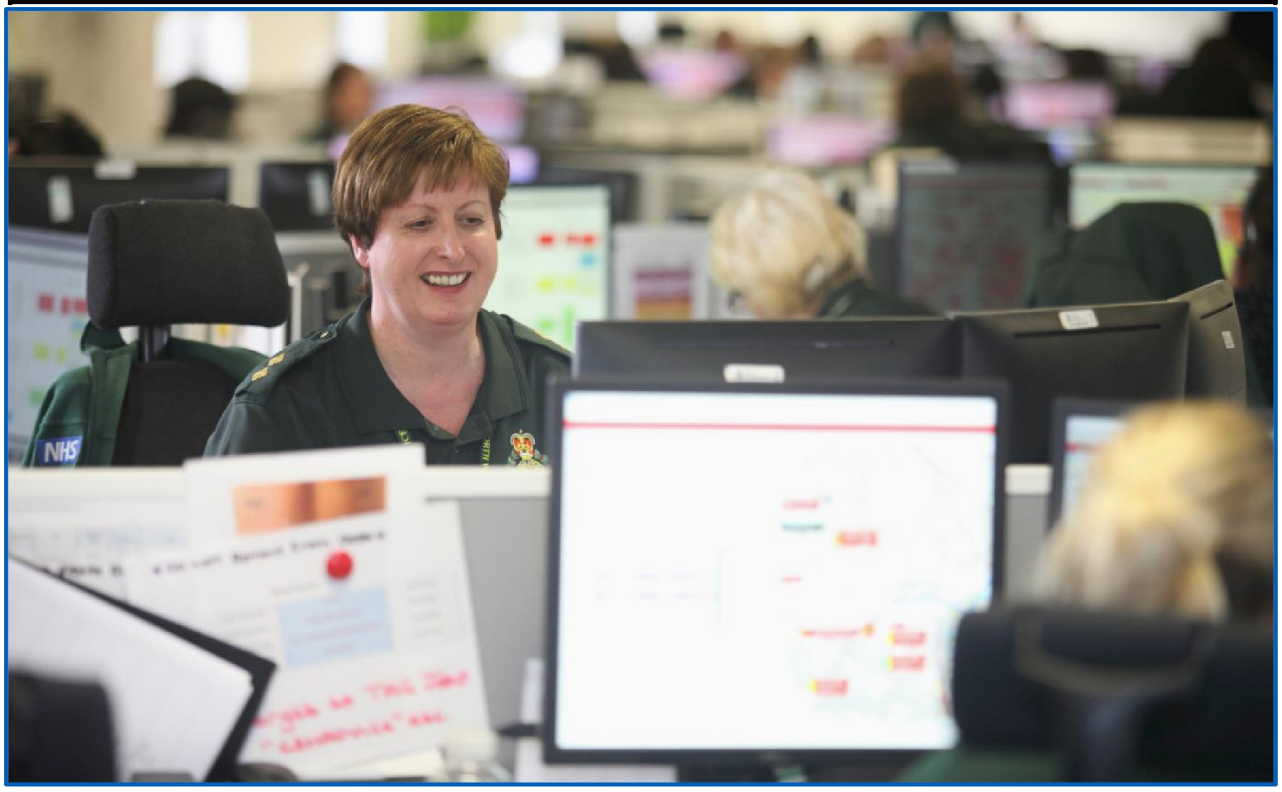
We operate three EOCs at Parkway (Greater Manchester), Broughton (Lancashire), and Estuary Point in Merseyside. While the EOCs are predominantly responsible for answering calls in Greater Manchester, Cumbria and Lancashire, and Cheshire and Merseyside respectively, they are able to work virtually to ensure robust business continuity and management of surges in activity by sharing the call and dispatch activity across all three EOCs. We also operate the North West NHS 111 service from its main site at Middlebrook in Bolton, two satellite sites at Estuary Point and Carlisle, and with a sub-contracted provider, Fylde Coast Medical Services, based in Blackpool.

Operational support is offered by a bespoke function based in Carlisle. The Carlisle Support Centre provides logistical support, coordination of clinical and safeguarding referrals, sickness management, and fleet issues. We know that our demand growth and associated need for support services to be robust is key.

In order to achieve our aim of greater integration between PES, IUC/111 and PTS, we will review and enhance the functions undertaken within the EOC and contact centres including the leadership and management structures. We will ensure that call-handling functions operate within the IUC environment to ensure prioritisation and streaming of patients is clinically robust and commensurate with patient needs.

Objective:

We will review and reconfigure our existing EOC and contact centre functions within the first two years of this strategy to ensure that we provide an efficient, appropriately resourced and resilient service at all times.



1.4 Interfacility transfer (IFT) / Healthcare Professional (HCP) Activity

We manage more than 175,000 calls from healthcare professionals and hospitals each year. This activity ranges from emergency admission requests from GPs, community nurses etc. to the movement of patients between hospital sites. The Association of Ambulance Chief Executives (AACE) has been working to produce a standardised policy for the effective management of this activity. The resulting framework has now been incorporated into the new 999 specification which came into effect on the 1 April 2018.

The purpose of the framework is to support system leaders in reducing unwarranted variation in the way ambulance services are provided and commissioned, in which the IFT/HCP frameworks determine how ambulance services manage IFT/HCP requests in a way that:

- Ensures equity of access for all serious ill or injured patients.
- Recognises that in certain situations, a healthcare professional may require immediate clinical assistance in order to make a life-saving intervention, in addition to ambulance transportation.
- Provides consistent definitions for high acuity healthcare professional responses that are established and mapped to ARP Category 1 and Category 2 response priorities.
- Offers opportunities for local innovation and acknowledgement of different contractual and commissioning arrangements for non-emergency healthcare professional requests.
- Allows responses to healthcare incidents to be measured separately to other 999 activity.

The process will also provide an auditable benchmark for us to evaluate and monitor the appropriateness of booking trends by healthcare professional users.

We understand that it is vital that booking healthcare professionals are well orientated with the frameworks and are thoroughly familiar with the defined response options contained therein. Information on the national frameworks and how to use our services is available on our website at: **http://www.nwas.nhs.uk/professionals**

We were selected as one of two English ambulance service pilot sites. The pilot will allow us to refine the proposed frameworks, ensuring the right technical and assessment systems are in place.

While a variety of processes were previously being employed across the pilot sites, a single IFT/HCP algorithm is now being used. Evaluation of the pilots will be coordinated through NHS England/Improvement.

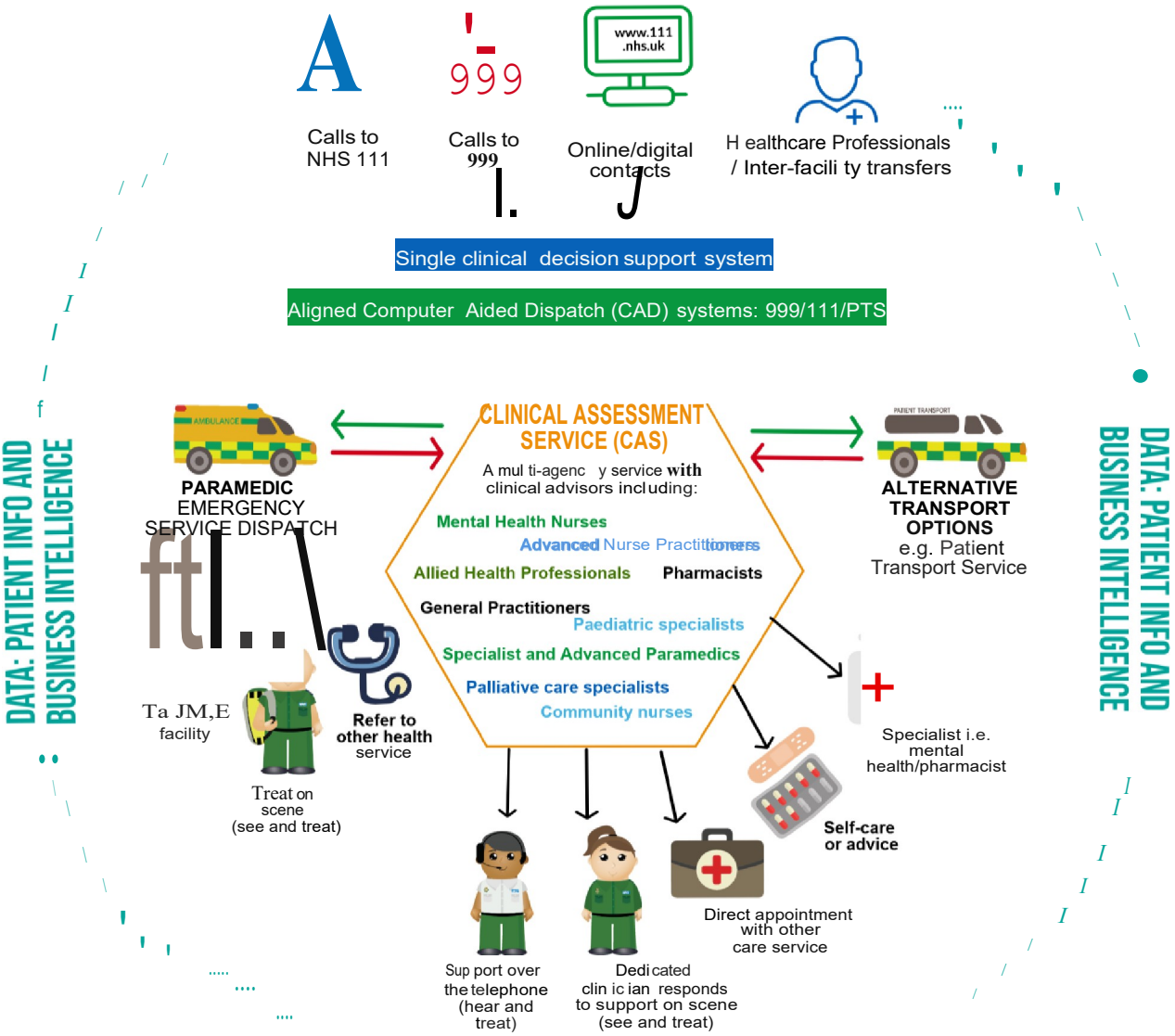
Objective:

We are committed to sustainably achieving all national response standards for IFT and HCP requests within the term of this strategy, in order to provide a fair and equitable response to all patients, every time.

Priority 2: Integrated urgent care

The basic principle of IUC is to provide safe care closer to home. This will help tackle the rising pressures on acute and urgent care services and reduce avoidable emergency admissions.

The following diagram illustrates our IUC model which harnesses the expertise and capacity within primary, urgent, and emergency care to provide a multi-disciplinary response to patients presenting to the system via 111 or 999. Patients will receive a complete episode of care concluding with either advice, a prescription, or an appointment for further assessment or treatment.



2.1 Clinical Assessment Service (CAS)

In line with the national recommendations, we will implement a single multi-disciplinary CAS which will integrate our NHS 111 and 999 Clinical Hub service with wider health and care partners.

ACAS will allow for a greater level of clinical expertise in assessing a patient that would normally be expected of a referring clinician. This expertise will be used to ensure that patients are directed efficiently and effectively into the most appropriate onward care pathway. The CAS will be staffed by multi-disciplinary healthcare professionals.

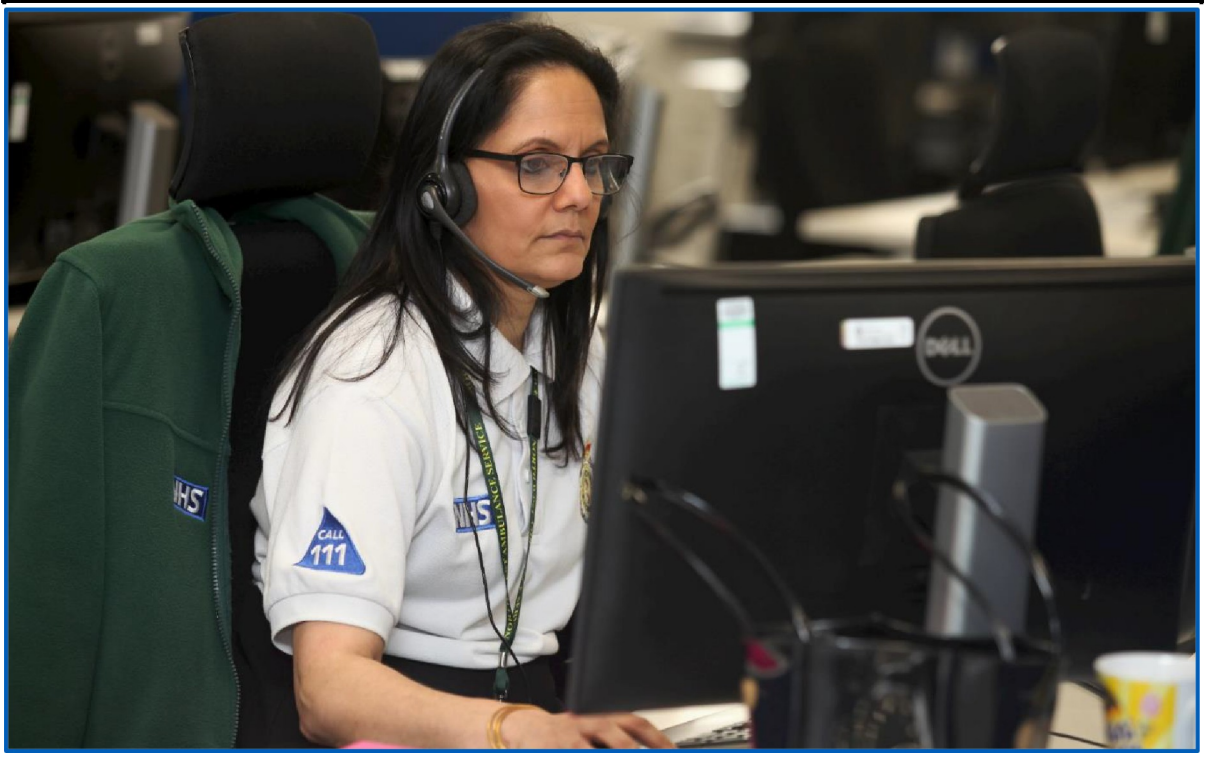
The CAS will utilise digital solutions to provide patients with a seamless journey and high quality care which is bespoke to their individual needs, regardless of the point of contact. In particular, we commit to aligning the primary triage systems within NHS 111 and 999 in order to increase the flexibility of workforce and reduce variation; resulting in greater consistency in the quality of triage outcomes.

We will also undertake a full review of the Computer Aided Dispatch (CAD) system in 999 and patient information platforms in 111 and PTS to ensure better integration and interoperability. Interoperability means that systems can talk to each other, enabling information to be shared so that health and care professionals have access to the information they need to provide the right care, in the right place, at the right time. Further detail is outlined within the Digital Strategy.

As IUC becomes embedded within the wider health system, a joined-up approach between 999, NHS 111, and community-based providers is essential. The need to ensure that the first contact of every 999 or 111 call is managed effectively is essential as the impact on the wider health system, is often, directly proportionate to decisions made at this point.

Objective:

We will commit to a fully integrated Clinical Assessment Service that will complement our resource dispatch functions within the first three years of this strategy.



2.2 Partnership working

We are perfectly placed as a lead partner in managing patient flow through the whole healthcare system therefore, it is essential that we further develop and maintain effective partnerships across the North West. We understand that implementation of IUC is crucial to the whole health system but that delivery cannot be achieved in isolation.

We recognise that partnerships with STPs will become crucial to delivery of IUC. We already engage STPs and commissioners to develop innovative, system-wide integrated response model which aligns to population demography and healthcare needs. This strategy describes our ambition to exceed current expectations to position NWAS at the forefront of the out of hospital health and care system.

In order to deliver the requirements of an IUC specification, we will continue to work in partnership with providers across the North West, including pharmacists, dental, mental health, maternity, GPs, with links to social care and other community services further strengthening these at all levels (board to frontline)

The commissioning arrangements for IUC will involve collaborative solutions between ambulance services, GP OOH, and other community based providers. Therefore, we will strengthen our existing engagement with commissioners and STPs to develop collaborative commissioning arrangements between the ambulance service, GP OOH, and other community based providers which will enable the implementation of a CAS.

Objective:

Engage with commissioners, STPs and providers to ensure that we are a key partner in delivering integrated urgent care solutions which align to population demography and healthcare needs, including prevention.

Engage with, and develop provider partnerships in order to implement an effective IUC model of care.

2.3 Health promotion and prevention

This strategy follows the principles of the NHS Constitution. We already engage with partner organisations such as Public Health England, Healthwatch, STPs, community services, and social care organisations in order to maximise our contribution to health promotion and prevention thus reducing demand on 999 services, accident and emergency departments, and the wider health system.

We will manage activity 'before the contact' through education and management of known high intensity users; both individual patients and care establishments such as nursing homes, residential homes and hospitals. We will support and engage in activities to assist initiatives that lead to better education and health management of the populations at regional or local level.

In line with our digital commitments to improve business intelligence, we will access and utilise high quality data from a range of sources to identify areas of preventable demand and proactively manage our resources. We will also use historic data to target public health communication to promote preventative self-care.

Priority 3: Service delivery models

3.1 Innovative workforce models

The future delivery of an IUC approach relies on enhanced clinical assessment and treatment in pre-hospital and community based settings. New models of care will require highly skilled, flexible clinicians who can work across traditional practice boundaries and within multi-disciplinary teams. Developing these clinical teams will require a more adaptable approach to clinical leadership in which urgent care capability is recognised as essential in enabling delivery of emergency services.

In the context of a limited national resource pool, recruitment and retention is crucial to our future plans and as clinicians increase their knowledge and skills we understand that to become an employer of choice, we must provide a rich experience for all staff, whatever their role. We must continue with our recruitment of a highly skilled and sustainable workforce as well as deploying, across a range of settings, clinicians with specialist skillsets such as mental health, pharmacy, midwifery, occupational therapy, and physiotherapy.

This strategy builds on the success of early rotational working pilots, flexible and shared workforce models as key enablers to the delivery IUC and CAS models and will provide exciting roles plus development opportunities for NWAS clinicians. This aligns to the recommendations published in Lord Carter's review which states that rotational working models can reduce staff turnover, alleviate demand issues across the NHS, enable staff to develop a wider skill-set and ultimately provide better care for patients.

We have already established a **"See and treat workforce development"** work-stream within the Transforming Patient Care programme. The programme explored the role that paramedics and other healthcare professionals can undertake in both the community and clinical telephone triage environments. Within the next twelve months we are committed to the expansion of the urgent care practitioner model to enhance see and treat capability focused on where this resource will addmost value. We are also working with a number of acute trusts to implement rotational paramedics within

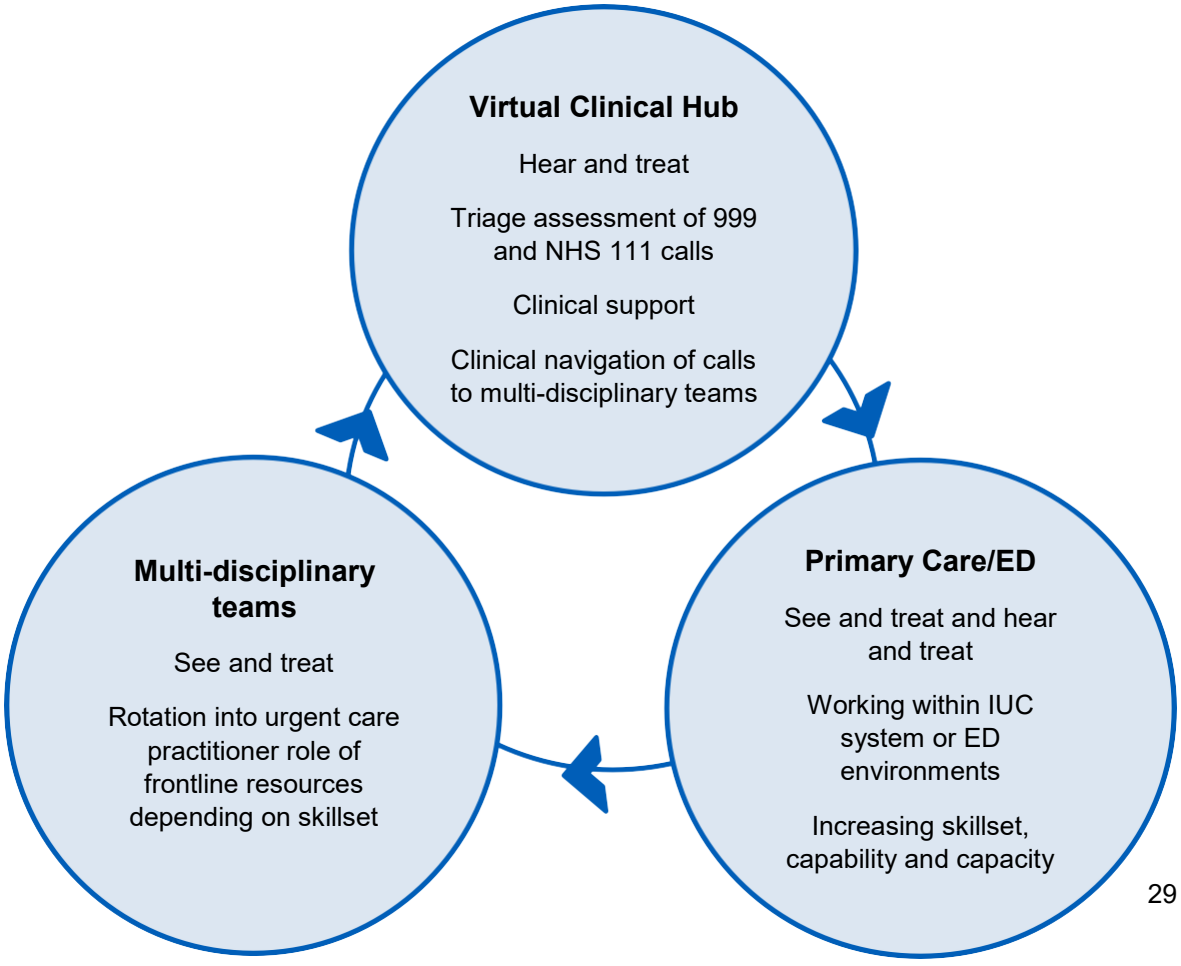
emergency department and primary care settings. Rotational practitioners can positively impact on other factors affecting our ability to deliver urgent and emergency care such as hospital handover delays by creating a steadier flow of admissions throughout the day.

As part of our approach to workforce development we will work closely with system-wide providers and academic partners in order to develop productive rotational working solutions.

During 2016/17 we introduced the role of the community specialist practitioner (CSP). Operating in twelve areas across the North West, the CSPs are usually based within a primary or urgent care setting. They often operate in isolated rural environments or communities where specific conditions can present a challenge to the health system such as diabetes, or chronic respiratory disease.

While the CSPs' primary responsibility is to provide a timely response to Category 1 or Category 2 999 calls, they also undertake engagement, health promotion, and prevention work with the local communities. CSPs also work with frequent users of 999 services, helping to develop care plans that can lead to effective management in a pre-hospital setting. The impact has been extremely positive for patients presenting with time critical symptoms and in reducing demand to the 999 system. We are committed to extending the CSP role in partnership with local CCG or STP requirements and will continue to evaluate the roles of specialist practitioners in the field.

The following diagram demonstrates the rotating model recommended by Health Education England. However, we intend to extend rotation to other healthcare professionals who have a valuable role to play in managing patients in the community. Using a variety of clinical backgrounds across a different clinical setting will help to provide the right response at the right time.



Allowing practitioners to rotate through a number of different operational placements will create exciting roles for nurses, paramedics, EMT1s and specialist practitioners within an IUC Service. The concept aims to enhance the reputation and attraction of NWAS as an employer, further develop integration with our partners across the health and social care economy and provide an opportunity to expand commercially.

These roles will form one of the cornerstones of the North West CAS and will support reductions in conveyance to emergency departments through enhanced see and treat and hear and treat, while supporting our Category 1 and Category 2 performance.

Our estates strategy is key to the delivery of innovation workforce models. This will support staff and our partners to work remotely and more flexibly; providing the opportunity to flex staff availability during spikes in activity.

3.2 Clinically-enhanced services

It is crucial to the delivery of our strategic aims, that we equip our workforce with the right clinical skills, decision-making tools and leadership.

We will develop its clinical workforce to ensure that our practitioners have the knowledge, skills and clinical expertise to assess, treat, diagnose, supply and administer medicines, manage, discharge and refer patients across a range of urgent, emergency, critical or out of hospital settings.

We will also provide our clinical workforce with robust decision making tools which support enhanced clinical triage and assessment. Clinicians within both NHS 111 and 999 use the Manchester Triage System Telephone Triage and Advice (MTS TTA) tool, providing a joined-up approach to clinical revalidation of primary NHS Pathways and MPDS outcomes. The Clinical Hub is staffed by a multi-disciplinary team of nurses, paramedics, mental health practitioners, and clinical pharmacists.

Clinical leadership is also an essential component of our delivery model. For many years we have operated a clinically fronted organisation. While we have developed a robust clinical leadership structure, the trust recognises that we need to move to a service model that will create a compelling vision for the future of urgent and emergency care delivery. The development of a service in which our clinical focus holds parity with our operational focus will enable the trust to deliver a more creatively designed, patient centred service delivering on both operational and clinical performance.

The structure for delivery of urgent and emergency care must now reflect the need for enhanced clinical leadership, dedicated operational management of resources and assets, and the required level of business knowledge and expertise in existing and emerging IUC partnerships.

Finding an effective balance between clinical leadership and general management is a trust priority to create an environment where clinically excellent, patient-centred care can flourish but where our services are delivered innovatively, efficiently and with high levels of productivity.

This requires us to develop a structure at STP level which enables leadership which can drive and aspire to clinical excellence, whilst also enabling a dedicated focus on all resource planning, logistics, staffing, and appropriate structures and systems in place to ensure the efficiency of resources.

In doing so, clinical and professional accountability of all staff undertaking clinical duties would directly align to the clinical structure, with similar managerial reporting lines, through to the Director of Operations. This structure will ensure that the day to day transactional business of operational management is achieved in a stable and efficient manner, while creating an environment in which clinical excellence, improvement, vision, and inspirational change becomes the first order.

Objective:

Within the first year of this strategy we will review the service delivery functions with a view to achieving an effective balance between clinical and operational leadership at STP level.

3.3 Urgent and emergency care structure

The ability to turn this strategic document into a successful large scale change programme will be almost entirely dependent on allocation of sufficient resources and an organisation structure that is designed around the strategic direction of the trust.

Delivery of the strategy will require a more effective balance between operational and clinical performance and leadership. The service delivery structure will continue to incorporate the vital components of both clinical leadership and operational management which better align with a service that delivers both urgent and emergency care. This reflects the need for maintaining high quality leadership in all operational areas, dedicated management of logistics (resources and assets), and detailed knowledge and expertise which may already be available within existing and emerging IUC partnerships.

In order to deliver highly effective urgent and emergency care, we recognise the need for all existing business lines to work as 'one service'. That is to say, Paramedic Emergency Services (PES), Patient Transport Service (PTS), and NHS 111, will operate in an integrated way to provide a single joined up response model. While PTS and NHS 111 are commissioned separately and have existing contractual commitments, the use of resources must be harnessed collectively across the three services, leading to efficiencies in staffing, clinical workforce, estates, fleet, and other infrastructure.

We also recognise the need for high degrees of expertise within each service, and understand that a 'one size fits all' approach to management and leadership will not drive the levels of performance and clinical excellence required over the term of this strategy.

Since the introduction of ARP in 2017, it has become increasingly apparent that the critical 'emergency response' provided by PES requires dedicated focus through a bespoke, highly experienced leadership structure. Further, delivery of IUC, including low acuity 999 activity, current NHS 111 activity, and specialist see and treat and hear and treat functions similarly require a thorough understanding and level of expertise, and acknowledgement of scale, especially in developing the integrated collaborative solutions required by CCGs and devolved healthcare arrangements. This must include an ability to consider system wide business opportunities in order to maximise the potential for locally determined models of care and the associated funding and investment opportunities.

PTS must be seen as not only a planned care provider, but a service that can support urgent and emergency activity profiles at times when activity is high or surges are experienced. We recognise the need to deliver the current PTS contractual obligations, but also understand that a 'one service' approach will be fundamental to our ability to manage demand from healthcare professionals and IFT demands.

While our services will not 'merge' they must functionally integrate in a way that harnesses the benefits of scale, share infrastructure, and workforce.

Objective:

- ✓ Within the first year of this strategy we will undertake a review of UEC structures that will enable the delivery of IUC at scale and pace; reflecting the need for leadership and operational structures which align to our strategic direction and maximising the available resource to effectively deliver, implement and sustain PES and IUC services across NWAS.

4. HOW WILL WE DELIVER THIS STRATEGY?

Enabling strategies

There are a number of strategies which are crucial to enable the delivery of this UEC Strategy. These include:

Digital

We recognise our ability to deliver the right care, in the right place, at the right time relies on investment in new technological solutions and therefore the need for UEC services to be supported by a robust digital strategy has never been more apparent. The adoption of digital technology will enable organisational transformation by creating efficiencies within our internal processes, while also providing greater integration into the wider health system.

Our digital strategy complements the principles and commitments of urgent and emergency care delivery. Through the adoption of secure, integrated digital solutions and robust business intelligence, we will reduce variation across service provision to provide a reliable, patient-centred response every time for those with both emergency and urgent care needs.

Workforce

The purpose of the workforce strategy is to set how we will develop, engage and empower our workforce to deliver our vision to become the best ambulance service in the UK. The strategy sets out our strategic workforce priorities and our approach to enabling the changes required in our workforce to support delivery of our strategic objectives.

Estates

The estates strategy is principally concerned with the utilisation of our estate and the capital investment over the next five years to ensure we can achieve our service objectives.

Fleet

Our fleet is a vital resource and fleet requirements need to be considered within the our planning of future resources. The fleet strategy aims to support the overall trust vision to become the best ambulance service by procuring a fleet which supports our current and developing operational models.

Communication and engagement

Effective communication with public, patients, staff and partners will improve the services that we provide, strengthen our reputation and achieve mutual understanding of our goals and the needs of our patients and staff. We embrace a commitment to listening and involving communities, their representatives and others in the way we plan and provide our services.

In order to ensure that patients must be as informed as possible about their options for treatment, medications, and other aspects of the ambulance service and the wider system providing their journey of care, we are committed to working together with patients to improve the care they receive. We will embed this through the newly

formed Patient and Public Panel and associated work plan of engagement and involvement activities.

Implementation plan

This strategy will be supported by a robust implementation plan which will centre on the creation of a shared vision. Responsibility for creating the shared vision will start with our Board of Directors, through the Executive Management Team, and continue to every member within operational, corporate, and support services.

We will adopt the following five-point framework for successful implementation:

1. Communicate and align

We will clearly communicate our objectives, all of which will be driven by our organisational values and vision.

We will have clear goals with a comprehensive list of business objectives that will become the foundation for improvement and change.

We will align the strategic principles and commitments with the business planning of each of the trust's directorates to ensure that all work aligns to and is prioritised against trust goals.

2. Drive accountability

The Chief Executive and Executive Management Team will ensure that our goals and objectives are shared with teams and individual staff members to ensure that everyone is clear how their contribution impacts on our success as the best ambulance service in the UK by 2023.

Objectives will be assigned to responsible officers. We will ensure that each responsible officer has clear action plans and objectives, and that they will be accountable, through a robust governance framework, for delivering those objectives.

3. Create focus

We will ensure that goals are realistic and achievable.

We will develop a series of dashboards that will allow staff to monitor their progress and see how their work contributes to the rest of the strategy implementation.

Regular and structured performance conversations will be established against each of the strategic principles, commitments and individual work-stream objectives.

4. Be action orientated

We will ensure that appropriate actions are taken when goals or objectives are not being achieved.

We will be supportive and proactive in action planning processes. Managers within will focus on the specific tasks needed to move their objectives forward in line with the strategic vision.

5. Track progress

A governance structure will be established in order to provide oversight and scrutiny and to allow each team to discuss progress against their implementation objectives.

Assurance on the delivery of our objectives will be provided through the Committee structure, reporting to the Board of Directors.

A full implementation plan will be developed to include a summary of objectives, deliverables, timescales, benefits and measures to go alongside 'left-shift' model.

5. CONCLUSION

The purpose of this strategy is to set an ambitious strategic direction for NWAS which informs and enables us to lead a robust response to regional, local, and national healthcare drivers.

We maintain our commitment to delivering the highest quality of care to those patients who present with time-critical illness or injury. Person-centered, outcome focused care will be our top priority. We will support our staff and patients to make confident decisions at all stages of the patient journey.

Our workforce is key. Innovative workforce solutions will drive the high quality of care for which we strive. We will explore rotational working solutions within emergency and urgent care that harness the skills, expertise, and capacity of our workforce. Health promotion, prevention initiatives, and the channel shift to community based care will be dependent on developing high calibre, versatile, and holistic practitioners.

Enhanced clinical leadership which empowers staff to be innovative, patient-centered, and quality driven, will complement existing general management functions. The addition of business and commercially focused managerial support will create a tripartite approach to service delivery which will adopt a rich, forward thinking approach to STP/ICS engagement.

We must digitally enable our workforce in order to promote interoperability and shared decision making, whilst also employing creative solutions for 'before the contact' healthcare.

The integrated response model approach will ensure that we functionally integrate the 999, 111, and PTS businesses, whilst harnessing capacity across the whole economy for the purposes of seamless patient care, in which needless waiting is eliminated.

In short, we are about to embark upon the largest organisational change process since the merger of legacy ambulance trusts in the North West. The challenge is there, and we are committed to embracing that challenge.

GLOSSARY OF TERMS	
AACE	Association of Ambulance Chief Executives
A&E	Accident and Emergency
APAS	Acute Primary Assessment Service
ARP	Ambulance Response Programme
CAD	Computer Aided Dispatch
CAS	Clinical Assessment Service
CHD	Coronary Heart Disease
CSP	Community Specialist Paramedic
CVD	Cardiovascular Disease
EMT	Emergency Medical Technician
EOC	Emergency Operations Centre
ePR	Electronic Patient Record
eTS	Electronic Triage System
EPRR	Emergency Preparedness, Resilience and Response
SYFV (FYFV)	Five Year forward View
GPOOH	General Practice Out of Hours
HART	Hazardous Area Rescue Team
HCP	Healthcare Professional
H&T	Hear and Treat
IFT	Interfacility Transfer
IUC	Integrated Urgent Care
IVCH	Integrated Virtual Clinical Hub
LTP	The NHS Long Term Plan
MDT	Multidisciplinary Team
MPDS	Medical Priority Dispatch System
MTS TTA	Manchester Triage System Telephone Triage and Advice
NAO	National Audit Office
NHSE	NHS England
NHSI	NHS Improvement
NWAS	North West Ambulance Service NHS Trust
PTS	Patient Transport Service
S&C	See & Convey
S&T	See & Treat
STP	Sustainability and Transformation Partnerships
TPC	Transforming Patient Care (Transformation Programme)
UCP	Urgent Care Practitioner
UECR	Urgent and Emergency Care Review